Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150097	A. BUILDING _____ B. WING _____	C 02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJOR HOSPITAL	150 W WASHINGTON ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint survey. Complaint Number: IN00100170 Substantiated and no citations Survey Date: 2-9-12 Facility Number: 005086 Survey Team: Jack I. Cohen, MHA Medical Surveyor Major Hospital was found in compliance with the 410 IAC 15-1.5-2 Infection control, and 15-1.5-8, Physical plant, environment and maintenance requirements for licensure rules. QA: claughlin 02/14/12	S 000		